PCSHealthSystems℠

PRESCRIPTION DRUG CLAIM FORM

STANDARD CLAIM

INSTRUCTIONS:

- This form is to provide direct reimbursement for prescriptions that were purchased without the use of your PCS card.
- **In order to process your claim(s) in the most timely manner, you must provide all information requested below.**
- Contact your pharmacist, if necessary, to provide the detailed drug information requested. **Receipts must be attached.**
- Do not submit this claim form until you receive your PCS card (from which you will obtain your identification numbers).
- Please use a separate claim form **for each patient.**
- If this is for an allergen charge, please use the allergen claim form.

INSURED INFORMATION:

Insured's Name: _____ (First / Middle / Last) Carrier #: 6091 Group #: _____

Street Address: _____ ID #: _____ Patient ID Code: _____

City: _____ State: _____ Zip: _____ Employer/ Company Name: Argonne National Laboratory

I certify that the information is correct and that the patient indicated below is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this claim form to PCS and the underwriter. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

INSURED'S SIGNATURE: _____

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: ____/____/____ Male: ____ Female: ____

Patient's Relationship to Insured:

Self ____ Spouse ____ Dependent ____

Check if Full-Time Student ____

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

NABP #: _____ Phone: _____

PHARMACIST'S SIGNATURE: _____

PRESCRIPTION CLAIM INFORMATION:

1 ℞ #: _____ New or Refill (circle one) Date Filled: ____/____/____ Quantity (ml., # tablets, gm., etc.): _____

Days Supply: _____ Name of Medication: _____

NDC #: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ___ No ___

Prescription Cost: $ _____ Tax: _____ Total Cost: $ _____

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2 ℞ #: _____ New or Refill (circle one) Date Filled: ____/____/____ Quantity (ml., # tablets, gm., etc.): _____

Days Supply: _____ Name of Medication: _____

NDC #: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ___ No ___

Prescription Cost: $ _____ Tax: _____ Total Cost: $ _____

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3 ℞ #: _____ New or Refill (circle one) Date Filled: ____/____/____ Quantity (ml., # tablets, gm., etc.): _____

Days Supply: _____ Name of Medication: _____

NDC #: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ___ No ___

Prescription Cost: $ _____ Tax: _____ Total Cost: $ _____
